Medicare Prescription Drug, Improvement, and Modernization Act of 2003

THE NEW MEDICARE PRESCRIPTION DRUG BENEFIT: COVERAGE / FORMULARIES

Section 1860D-4

- The Medicare drug benefit will cover all FDA-approved drugs and biologicals normally covered in the Medicaid program, as well as insulin and supplies associated with taking insulin and drugs that help people to stop smoking.

- Individual Medicare prescription drug plans will be able to set up selective formularies for their plan. These formularies may be closed formularies, in which the plan only covers certain drugs, or open formularies, in which all drugs are covered, but beneficiaries receive preferred drugs for lower co-pays than non-preferred drugs. In any case, the plans are required to include drugs in every therapeutic category on their formularies, and beneficiaries will be able to check the coverage status of specific drugs when selecting plans.

- In setting up a formulary, the plan must have a pharmacy and therapeutic committee consisting of practicing doctors and pharmacists, including providers who have expertise in the treatment of seniors and the disabled. When choosing drugs for the formulary, the plans must also be mindful of the drug's specific therapeutic advantages.

- Formularies and variable co-pays are important tools for plans to manage drug costs and keep the Medicare drug benefit affordable. They enable plans to steer drug utilization to preferred drugs and generics, saving beneficiaries money through rebates that the plans negotiate with drug manufacturers.

- When approving plans, Medicare will review the formulary to make sure that it is not designed in a way that will discourage enrollment by people with certain types of medical conditions.

- If a beneficiary finds that the drug he or she needs is not on the plan's formulary (or is on a non-preferred cost-sharing tier), then an appeal is possible. A doctor would need to certify that the drugs on the formulary are not as effective or would adversely affect the beneficiary. If the appeal is successful, then the beneficiary can get the drug as though it were on the formulary (or preferred tier), and any cost-sharing amounts paid will count toward the out-of-pocket limit.